Surveyor Notes Worksheet

Facility Name: XYZ Hospital **Facility ID:** 000000

Surveyor Name/ID: Jane Smith, RN/35493

Care Area(s)/Activity: Complaint

Enter the time, source, and documentation.

Date and Time	Source and Documentation
11/08/2009 0800	Entrance to hospital lobby. Presented cards to receptionist. Requested to meet with Administrator.
0845	Met with DON and administrator. Provided list of required items for survey, requested area to work, and anticipated length of survey.
	Patient #1 Record Review Admission Date: 5/16/2009 PMH: Hx of bipolar, ETOH abuse, depression. Severe pancreatitis since 10/08. Frequent hospital admissions since diagnosis with chronic abdominal pain, frequent n & v, and diarrhea. Acute Hospital Records: 5/8/09: Admitted with severe pancreatitis 5/8/09: Weight 146 lbs 5/12/09: GI consult "may need parenteral nutrition or referral to regional teaching hospital" if intake and nutritional status do not improve. 5/12/09: Labs–Albumin 1.0 g/dl (nml 3.4-5.0 g/dl), calcium 7.5 g/dl (nml 8.4-10.6 g/dl), and total protein 3.3 g/dl (nml 6.4-8.2 g/dl). 5/13/09: Nurse notes–low K+ and low Mg. Exact levels not found. Chronic abdominal pain, frequent n & v, and diarrhea throughout stay. 5/16/09: Transfer to Rehab hospital. 5/16/09: Initial Nursing Assessment at 3:00 PM. Chronic abdominal pain, n & v, diarrhea
1300	Received personnel files for dietician and treating physicians.
1330	Record Review: 5/18/09: Initial Dietician Assessment Weight at 146 lbs. No indication if this is actual weight or a patient-stated weight. Pt #1 is “80% of ideal body weight.” “I’ve lost 75 lbs. over the last year.” 5/18/09: Nurse's notes–pt #1 eating “fair” to “good” during the first 48 hours 5/18/09: LPN notes–pt #1 appetite “poor to fair (less than 50% consumed),” n & v, diarrhea. B/P of 85/50. 5/18/09: Physician orders for oral pancreatic enzymes and Ultram. 5/21/09: Nurse notes–Pt #1 complained of pain. Physician ordered Dilaudid. No physical description of patient in records.

Date and Time	Source and Documentation
1400	Interview with DON: Requested copies of patient weight and calorie intake. "They should be in the medical records." Interview with attending: "The patient indicated he had nausea and abdominal pain. I ordered Ultram for pain." "There was no indication of malnutrition."
1430	Record Review: 5/19/09: Physician orders for weekly weight and to push fluids. No record of pt weight for 5/19/09 thru 6/2/09. No record of pt calorie intake for 5/19/09 through 6/2/09. B/P of 84/52. 5/27/09: B/P 79/53 5/28/09: B/P 84/53 6/2/09: Dieticians notes–"significant weight loss" and "high risk." Recommended pre-albumin test. Also recommended that if patient's oral intake did not improve, "tube feedings" should be considered. No record of pre-albumin test in records. 6/3/09: Physician order for oral appetite stimulate at 1300 6/3/09: LPN notes–pt #1 "severe abdominal pain" at 2300. Physician ordered OxyContin. Pt refused meal at 1800. 6/4/09: LPN notes–pt #1 received oral appetite stimulant at 0800 6/4/09: B/P 78/50 6/5/09: LPN notes–pt #1 received oral appetite stimulate at 1130 6/5/09: Gastroenterologist notes–pt #1 "profoundly malnourished," "low albumin, anasarca, and hypoalbuminemic ascites." Ordered diagnostic test. Recommended "if patient's albumin did not improve, should be transferred to regional referral center for a second opinion and to plan for long-term gastrointestinal needs." 6/5/09: Physician notes–pt #1 may need to be transferred "in the future" because of poor nutrition. 6/6/09: LPN notes–pt #1 received oral appetite stimulate at 1130 6/6/09: Physician notes–pt #1 "seeing spots and has blurred vision." Pt refused meals at 1130 and 1800. 6/7/09: Nurse notes at 0115–pt #1 having "visual disturbances with weakness." B/P 60/50. Pt #1 transferred to ED of acute hospital at 0215 on 6/7/09. 6/7/09: ED records–pt #1 arrived 0230 with a B/P of 48/27. Physician order for vasoactives. Diagnosis of sepsis and pneumonia. Physician ordered labs for albumin and protein at 0300. Pt #1 developed respiratory distress and cardiac arrest at 0600. Resuscitation attempted. Pt #1 expired at 0620. Labs: albumin 0.5 g/dl, total protein 2.8 g/dl.
1645	Interview with DON: Asked DON about pre-albumin test. No knowledge of test being done.
11/09/2009 0800	Review of interdisciplinary team conference meetings for pt #1. Meetings held on 5/21/2009 and 5/30/2009. No mention of pt #1 nutritional status or concerns.

Date and Time	Source and Documentation
0820	Record Review: Physical Therapist's notes–pt #1 "weak, poor endurance" and "not feeling well." Pt #1 refused treatment on 6/1/2009 through 6/3/2009. Therapy canceled 5/27/2009, 5/28/2009, and 6/4/2009 due to "low B/P and weakness." No mention of malnutrition in notes.